

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 013149	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/21/2016
NAME OF PROVIDER OR SUPPLIER MORNING VIEW NURSING AND REHABILITATION CEI		STREET ADDRESS, CITY, STATE, ZIP CODE 475 NORTH NILES AVENUE SOUTH BEND, IN 46617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p>INITIAL COMMENTS</p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey date: June 21, 2016</p> <p>Facility number: 013149 Provider number: 013149 AIM number: N/A</p> <p>Residential Census: 38 Total: 38</p> <p>Sample: 7</p> <p>Morning View Nursing and Rehabilitation Center was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>QR was completed by 99993 on 06/22/16.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE